

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004440	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/24/2015
NAME OF PROVIDER OR SUPPLIER CHANDLER PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2879 S LIMA RD KENDALLVILLE, IN 46755		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of complaint IN00164938.</p> <p>Complaint IN00164938- Substantiated, no deficiencies related to the allegations are cited.</p> <p>Survey Dates: February 24, 2015</p> <p>Facility number: 004440 Provider number: N/A AIM number: N/A</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: Residential: 31 Total: 31</p> <p>Census payor type: Other: 31 Total: 31</p> <p>Sample: 3</p> <p>Chandler Place was found to be in compliance with 410 IAC 16.2-5 in regard to the investigation of complaint IN00164938.</p> <p>Quality Review 02/25/15 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE